PATIENT QUESTIONNAIRE

Learn2EatRight

Demographic Data

Name_____ Date_____
Address_____ Home Phone_____
_____ Office Phone_____
Fax_____ Cell Phone_____
Sex M F Age_____ Birth date _____ Height ___'___"
E-mail_____

Health History

What medical concern (e.g., high blood pressure), if any, do you have at the present time?
_____

Indicate whether you have had blood relative with any of the following problems:

Cancer	yes	no	High blood pressure	yes	no
Diabetes	yes	no	Osteoporosis	yes	no
Heart disease	yes	no	Thyroid disorder	yes	no
High cholesterol	yes	no			

Do you have complaints about any of the following?

___Appetite	___Constipation	___ Menstrual difficulties
___Sudden weight change	___ Edema	___ Stress
___ Diarrhea	___ Indigestion	___ Low energy
___ Insomnia	___ Nausea	___Reflux/heartburn

___ Allergies _____
___Other_____

Do you use tobacco in any way? yes no How much? _____
Did you recently stop smoking yes no

Do you enjoy physical activity yes no Explain _____
_____

List any food allergies or intolerances?

_____ _____
_____ _____

Drug History

List any prescribed, over-the-counter medicine, herbal, or vitamin/mineral supplements you take.

_____ _____
_____ _____
_____ _____
_____ _____

Diet History

Do you follow a special dietary plan, such as low cholesterol, kosher, or vegetarian?
_____

Have you ever followed a special diet? _____ Explain_____

Do you eat at regular times each day? _____ How often? _____

What are your least favorite foods? _____

What are your favorite foods? _____

Do you drink alcohol? _____ How often? _____

Do you drink caffeine?_____, if yes, how much? (i.e. drinks/week)

What change(s) would you like to make?

___Improve my eating habits ___Improve my activity level
___Learn to manage my weight ___Improve my cholesterol/triglyceride levels
___Body composition ___Portion Control
___Other_____

Have you ever noticed sensitivity to:

___ Milk products (milk, yogurt, ice cream, etc.) ___Fats
___ Wheat (bread, pasta, cereal, thick sauces, etc.) ___Fresh fruit

___ Seafood (shrimp, lobster, muscles, clams) ___Dried fruit

To tailor your counseling experience to your needs, it would be useful to know your expectations. Please check one of the following to indicate the amount of structure you believe meets your needs:

___Tell me exactly what to eat for all my meals and snacks, I want a detailed food plan.

___I want a lot of structure but freedom to select foods from a food group plan.

___I don't want a diet. I just want to eat better. I will just set food goals each week.

Socioeconomic History

Are you employed? ____ Occupation _____

How many people in your household? ____ Ages _____

Present marital status (circle one):

Single Married Divorced Widowed Separated Engaged

Who prepares most of the meals in your home? _____ Shopping _____

Do you use convenience foods daily? yes no
If yes please describe_____

How often do you eat out? _____ Where_____

Have you made any food change(s) in your life you feel good about yes no

If yes who supported and encouraged you to make these change(s)?
_____

Education Interests

Please check **ALL** areas you hope to address though your relationship with a nutritionist:

___Weight management
___Emotional eating
___ Healthy food preparation
___Analyze supplement needs
___Gain of lean mass
___Weight gain
___Loss of body fat
___Weight loss

___ High fiber foods
___ Reading food labels
___Learn how eat better with a hectic schedule
___Exercise programs
___ How to eat healthy in restaurants
___ Healthy carbohydrates
___ Calorie burning activities

___Improvement of mood
___Prevent illness
___General health improvement

Learn2EatRight Patient Agreement (please read & sign below):

1. I agree that all the information presented here is truthful to the best of my knowledge.
2. I agree to a 24 hour cancellation policy to (310) 444-9755 or email to learn2eatright@yahoo.com otherwise I will be billed for the visit.

Patient Signature_____Date_____

Thank you. I look forward to working with you and achieving your personal health goals.